Three other conclusions emerge from these studies. Firstly, contrary to gut feelings, the group of patients described either as frequent attenders or "heartsink" does not remain static but changes over several years (p 528).¹⁸ The needs that are being satisfied by their behaviour are neither constant nor indefinite.

Secondly, despite the honesty of these writers they all focus on the patients' characteristics rather than on the contribution of their own personality to the problem. For instance, a study of patients with systemic lupus erythematosus found that four doctors most disliked patients with psychiatric symptoms. The authors concluded that dislike could be used as a diagnostic tool to predict psychiatric illness but did not consider whether this showed a prejudice among the doctors.¹⁹ This is an example of attribution bias, in which the observer takes credit for success and denies responsibility for failure.²⁰ Exceptionally, Illingworth has admitted that irritation often arises from the doctor's intolerance, impatience, fatigue, hunger, or pressure of work.²¹

Thirdly, this painful topic has been avoided by most British hospital doctors. This may be because these feelings usually arise in long term relationships, which most hospital doctors are not required to form.

Balint's pioneering work with general practitioners showed the value of small groups for exploring sensitive areas of practice.²² Such groups provide a constructive setting for the first step in dealing with negative feelings: admitting their existence to ourselves and our peers and drawing up an agreed policy for individual patients.^{15 16} Ideally, the policy could be negotiated with the patients themselves, but the fact that they have acquired the label "heartsink" may mean that it has already been difficult for the practice to agree goals with them. At best, doctors' negative emotions may be discussed and used as part of treatment to explore the reasons patients have for wanting to punish doctors and be punished by them. Many doctors and patients will find this technique too difficult or intrusive; as O'Dowd's study hints some patients will choose to find another doctor with whom they can

maintain a more distant relationship (p 528). Doctors should assess how much of the problem is attributable to their own attitudes or working practices. Getting outside their own emotions will also help them to see the problems from patients' points of view; some of the irritation will be reduced by empathetic understanding shared with colleagues.

Such a programme will not make all patients more likeable. Some will continue to evoke negative feelings whatever is tried. For them doctors should state clearly what they can and cannot provide so that they can answer patients' medical needs without spending too much of their own time in unrewarding or humiliating encounters.¹²

DAVID JEWELL

Consultant Senior Lecturer in General Practice,
University of Bristol,
Department of Epidemiology and Community Medicine,
Canyng Hall,
Bristol BS8 2LA

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The code for promoting drugs

Can do little to limit overenthusiastic advocacy

Codes of practice are in vogue. They have been promulgated for the Stock Exchange, marketing in general, and the pharmaceutical industry in particular. They principally regulate affairs when formal legislation does not exist or standards of conduct are needed that go beyond what legislation may require. The code of practice of the Association of the British Pharmaceutical Industry tries to define good standards of marketing practice. Does it succeed?

The code lays down in over 20 major clauses and multiple subclauses what is or is not acceptable in promoting drugs. Some of the clauses are straightforward exhortations—"Methods of promotion must never be such as to bring discredit upon, or reduce confidence in, the pharmaceutical industry." Others are statements of intent—"Information about medical products should accurately reflect current knowledge or responsible opinion . . . must be accurate, balanced and must not mislead either directly or by implication . . . [and] must be capable of substantiation." Apart from these general statements there are specific injunctions—such as that "new" should not be used in describing products that have been available for over 12 months. Superlatives and hanging comparatives—such as "better" or "stronger"—

should not be used: "Claims for superior potency per unit weight are meaningless . . . unless linked to some practical advantage." Descriptions are also included of what may appear in promotional material, of appropriate means of graphic display, and of conduct during discussion with doctors.

If the consumer (in this case the prescribing doctor) is educated and intelligent, if there is free access to unbiased sources of information, and if prescribing does not bring a differential reward according to the agent prescribed we should have cost effective and efficient prescribing. Unfortunately there is little reason for believing that this is how things are. Although prescribers do not gain (except in prescribing practices) from choosing the more rather than the less expensive drug, the pressures to be cost effective are limited. In addition, the short snappy messages of advertisers tend inevitably to be more memorable than the measured cadences of official or semiofficial publications exhorting prescribers to be cost effective. This might not matter if clinical differences between drugs were always obvious.

If, as is likely, slogans are better received than sense, does the code amount to more than window dressing? If the code

were indeed limiting and bore heavily on those promoting drugs we might expect plentiful evidence of possible transgressions. If issue number 20 of *Reports to Chief Executives in the Pharmaceutical Industry* is anything to go by evidence of transgressions is limited. Nine possible cases were examined with four rulings of breach and five of no breach. Breaches included a misleading use of a graphic aid by a representative and a misleading claim (how to stop 5% of your patients taking up 25% of your time) for a psychotropic drug. In addition, an advertiser had quoted from an article that was six years old and claimed it to be recent, and another company had issued an invitation to doctors' spouses as well as to doctors themselves.

Assuming that these are the best or rather the worst cases, we can conclude that misleading promotion scarcely occurs and that the industry is careful and respectful of its code. An alternative explanation is that transgressions do not occur because there are plentiful means of exploiting real differences, minor or major, or gently manipulating data to advantage. The Medicines Act 1968 contains provisions that medicines shall be generally safe and effective but does not take account of comparative efficacy. In the same way

advertisers do not have to take cognisance of what is actually the best buy, hence perhaps the tendency to vague hype in the promotion of drugs. An even more difficult issue is that of comparative safety. Drugs within classes tend to have similar patterns of adverse effects, and because clinical practice is not a large scale randomised trial and drug usage, promotions, and patterns will vary we have difficulty in drawing clear conclusions about league tables of safety. Postmarketing surveillance seems particularly unhelpful as the studies usually lack the power to detect adverse effects or the ability to discriminate between natural events and those induced by drugs. It is also rare for comparative studies to emerge, or if comparative data do exist the comparability is doubtful.

Given all these difficulties, I cannot see how any code of practice, however honourable, can limit any but the most obvious forms of overenthusiastic advocacy. The maxims of caveat emptor and reading the small print must continue to apply.

MICHAEL LANGMAN

Professor of Medicine,
Queen Elizabeth Hospital,
Birmingham B15 2TH

Crisis in the maternity services

Recent complaints are right

Harriet Harman, the shadow health minister, recently wrote to Tony Newton, the health minister, identifying serious problems in the English maternity services (23 April, p 1201). Are her claims justified?

Between 1981 and 1986 staffed maternity beds were reduced and births increased in every region in England.^{1,2} Overall, however, bed occupancy has not increased, presumably because of shorter stays both before and after birth. This is a cause for concern because the higher dependency of women occupying hospital beds increases the workload of the midwifery and medical staff for each bed. For an individual hospital, bed occupancies of 65-75% may be acceptable, but over a region they must mean overcrowding in some hospitals because women having babies are not evenly distributed. A bed somewhere in a region may not be available to a woman in labour who has to reach hospital quickly; and continuity of care is impossible if women have to go somewhere other than the place of booking at the last minute. The regions with the most births for each bed are South West Thames, North West Thames, North East Thames, Oxford, and the West Midlands.

There are also fewer special care cots for more babies.^{1,3} Particularly worrying is the fact that the number of low birthweight babies for each cot has increased. In 1986 the perinatal and infant mortality were the highest in the regions with the most low birthweight babies for each cot, suggesting that shortage of beds may contribute to mortality. More serious problems (not mentioned by Ms Harman, perhaps because no national or regional data exist) are that intensive care costs are unevenly and insufficiently available and that designated cots are rarely adequately staffed.⁴ These problems in the NHS are exacerbated by the increase in multiple births generated by assisted reproduction (done mainly in the private sector).⁵ The availability of intensive neonatal care improves mortality⁶ and the care of at least the larger very low birthweight babies is cost effective.⁷ Investment in neonatal care is necessary, but designation of intensive care cots is essential for monitoring services.

The 1986 rise in infant mortality resulted mostly from a rise

in postneonatal deaths, which are usually held to reflect social conditions rather than provision of services.⁸ There is controversy over whether social class differentials are inevitable or might respond to social or medical initiatives,⁹ but better methods of identifying the social determinants of women's health are required.¹⁰

Ms Harman is right to abhor complacency in accepting interregional variations in mortality, and the contrast she draws between the high mortality in the West Midlands and the low mortality in East Anglia is consistent between 1981 and 1986. Interpretation of the differences really requires detailed assessment of the cause of death; attention to possible differences in the extent to which deliveries after very short gestations are registered; and linkage of maternal and neonatal data as neonates at high risk often cross interdistrict or interregional boundaries.¹¹⁻¹³

Clear evidence of the comparative safety of different sizes of maternity units is lacking,¹⁴ though for surgery,¹⁵ assisted reproduction,⁵ and obstetric anaesthesia¹⁶ small does not always seem to be beautiful. Closures of small maternity units are usually unpopular, but it is difficult to argue that they can never be justified even when bed occupancy is low and the number of births insufficient to maintain the skills of staff. Requiring district health authorities to provide a choice of hospital settings for childbirth for every woman is also unrealistic, though a choice should always be offered for how the delivery is conducted.

Perhaps the most serious problem to which Ms Harman draws attention is the crisis in midwifery staffing. There is an 18% shortage of staff midwives, with much graver shortfalls in some places,¹⁷ and the shortages increase stress for the remaining staff. The new clinical grading structure offers an opportunity to correct the longstanding anomaly whereby neither the additional training nor the unique clinical responsibilities of midwives has any financial recognition. Surely the minimum grading for trained staff is inappropriate for practising midwives, who provide much antenatal and postnatal care and conduct most deliveries? Furthermore, staff doing shift work in labour wards and special nurseries need